VERMONT

AGENCY OF HUMAN SERVICES

DEPARTMENT OF DISABILITIES, AGING AND INDEPENDENT LIVING

Division of Licensing and Protection
HC 2 South, 280 State Drive
Waterbury, VT 05671-2060
http://www.dail.vermont.gov
Survey and Certification Voice/TTY (802) 241-0480
Survey and Certification Fax (802) 241-0343
Survey and Certification Reporting Line: (888) 700-5330
To Report Adult Abuse: (800) 564-1612

December 20, 2016

Ms. Joyce Jacobs, Manager
Windover House
451 Vt Route 66
Randolph, VT 05060-9387

Dear Ms. Jacobs:

Enclosed is a copy of your acceptable plans of correction for the survey conducted on October 31, 2016. Please post this document in a prominent place in your facility.

We may follow-up to verify that substantial compliance has been achieved and maintained. If we find that your facility has failed to achieve or maintain substantial compliance, remedies may be imposed.

Sincerely,

Pamela M. Cota, RN
Licensing Chief

Division of Licensing and Protection

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0109	A. BUILDING: _____ B. WING _____	10/31/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WINDOVER HOUSE	451 VT ROUTE 66 RANDOLPH, VT 05060

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R100	Initial Comments: An unannounced, on-site re-licensing survey was conducted by the Division of Licensing and Protection on 10/31/16. The following regulatory deficiencies were identified:	R100		
R136 SS=E	V. RESIDENT CARE AND HOME SERVICES 5.7. Assessment 5.7.c Each resident shall also be reassessed annually and at any point in which there is a change in the resident's physical or mental condition. This REQUIREMENT is not met as evidenced by: Based on observation, record review and confirmed by staff interview the facility failed to complete an annual assessment for 2 of 3 sampled residents, utilizing the State required instrument. For Resident #2 and #3, the findings include the following: 1. Per medical record review, Resident #2 previously had an assessment completed on 10/15/15. An additional date of 4/20/16 is identified in writing as a reassessment signed by the Registered Nurse (RN). There are various notations through out the assessment with additional comments that identify changes, but have no signature/initials or date to identify a new assessment or change in condition. 2. Per medical record review, Resident #3 previously had an assessment completed on	R136	Please see attached plans of correction. Completed on 10-31-16	

Division of Licensing and Protection
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE TITLE (X6) DATE

R136 - R302 POCs accepted with attached addendum 12/20/16
MBertrand RN | PME

11-25-16

STATEMENT OF DEFICIENCIES AND PLAN DF CDRRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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R136	Continued From page 1 10/15/15. An additional date of 4/13/16 identified in writing as reassessment signed by the Registered Nurse (RN). There are various notations through out the assessment with additional comments that identify changes, but have no signature/initials or date to identify a new assessment or change in condition. Per interview with the RN at approximately 1:40 PM, confirmation was made that s/he has only been with the facility since 3/2016 and was unaware that a new assessment must be completed annually. S/He also confirms that s/he was trying to familiarize her/himself with the residents and made notations on the previous assessments that both had been dated 10/15/15. Confirmation is also made that the annual assessments are late.	R136	Completed on 11-2-16. All are now current.	
R145 SS=D	V. RESIDENT CARE AND HOME SERVICES 5.9.c (2) Oversee development of a written plan of care for each resident that is based on abilities and needs as identified in the resident assessment. A plan of care must describe the care and services necessary to assist the resident to maintain independence and well-being; This REQUIREMENT is not met as evidenced by: Based on observation, record review and staff interview the facility failed to update the resident's plan of care for 1 of 3 sampled residents that address current needs and services necessary to	R145	This Plan of Care has been updated as of 11-2-16 and 11-23-16.	

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R145	Continued From page 2 assist the resident in maintaining independence and well being. For Resident #3 the findings include the following: Per medical record review at 12:15 PM, Resident #3 had an annual re-assessment completed on 10/15/15. The care plan was updated on 4/27/16 evidenced by the Registered Nurse (RN) signature. Resident was seen on 9/26/16 by a physician after an unwitnessed fall on 9/15/16. Physician documentation identifies the resident had a fall and hit his/her head and also has a vaginal pessary in place. The resident receives a blood thinner daily to manager a heart condition of Atrial Fibrillation. Per review of the comprehensive care plan, there is no evidence identifying the recent fall nor are there initiatives identified to avoid future falls. No direction from professional staff related to management of this resident who receives anticoagulant medication daily nor is there any notation related to the pessary, management of or monitoring of the internal device. Confirmation by the RN at 1:40 PM that the care plan does not identify the resident's current status.	R145	updated as of 11-2-16. Pessary was Removed by Dr. on 11-10-16.	
R153 SS=E	V. RESIDENT CARE AND HOME SERVICES 5.9.c (10) Monitor stability of each resident's weight; This REQUIREMENT is not met as evidenced by: Based on observation, record review and staff interview the facility failed to consistently monitor weights for 2 of the 2 sampled residents. For	R153	Monthly weights are done and recorded.	

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R153	Continued From page 3 Resident #1 and #3, the findings include the following: 1. Per medical record review at 10:50 AM, Resident #1 was admitted on 10/3/2000 with diagnoses to include Diabetes, hypertension, Congested Heart Failure and Chronic Renal Insufficiency. The resident receives a diuretic twice a day to manage his/her health conditions. Routine monthly vital sign sheet identifies last documented weight in July 2016. 2. Per medical record review at 12:15 PM, Resident #3 was admitted on 9/16/13 with diagnoses to include Hypertension and acute Right Heart Failure. The resident receives a diuretic daily to manage his/her health conditions. Routine monthly vital sign sheet identifies last documented weight in March of 2016. Per interview with the owner and the Registered Nurse at approximately 2:30 PM that the weights have not been monitored consistently. Owner states "I take them, I just didn't write it down".	R153	weights/vital signs are monitored and recorded.	
R179 SS=E	V. RESIDENT CARE AND HOME SERVICES 5.11 Staff Services 5.11.b The home must ensure that staff demonstrate competency in the skills and techniques they are expected to perform before providing any direct care to residents. There shall be at least twelve (12) hours of training each year for each staff person providing direct care to residents. The training must include, but is not limited to, the following:	R179		

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R179	Continued From page 4 (1) Resident rights; (2) Fire safety and emergency evacuation; (3) Resident emergency response procedures, such as the Heimlich maneuver, accidents, police or ambulance contact and first aid; (4) Policies and procedures regarding mandatory reports of abuse, neglect and exploitation; (5) Respectful and effective interaction with residents; (6) Infection control measures, including but not limited to, handwashing, handling of linens, maintaining clean environments, blood borne pathogens and universal precautions; and (7) General supervision and care of residents. This REQUIREMENT is not met as evidenced by: Based on employee record review and staff interview the home failed to ensure that staff receive the required training that included the 7 topics. The findings are as follows: Per review of two (2) employee files at 11 AM, they have no documented evidence that they have received the required education over the past 12 months. The two (2) owners also have not had any evidence that the required education has been completed. Per interview with the owner at 11 AM, confirmation was made that no education has been completed for any of the listed employees in the past year. The owner is aware of the requirement, but more acceptable to receive a deficiency rather then meet the requirements. (This was cited during 2012 relicensing survey.)	R179	In process - PERK Tests have been procured from Gifford medical Center for the staff In process - see above	

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R190	Continued From page 5	R190		
R190 SS=E	V. RESIDENT CARE AND HOME SERVICES 5.12.b.(4) The results of the criminal record and adult abuse registry checks for all staff. This REQUIREMENT is not met as evidenced by: Based on record review and staff interview the home failed to maintain on file the results of adult and child abuse registry checks for 4 of 5 sampled staff to include both owners. The findings include the following: Per review of employee records, there is no evidence of any adult or child abuse registry checks on file at the home. During an interview at 9:50 AM, the owner connected the surveyor on the phone with the individual who completes the criminal background checks for the facility. That contracted employee confirmed that the adult and child abuse registry checks have not been completed for the 4 employees in the sample. This review does include the two owners that also have not had criminal or abuse registry reviews completed. The surveyor provided the appropriate contact information for the procedure. (This was cited during 2014 relicensing survey.)	R190	Background/Criminal record check confirmation has been received for three from Gifford medical center. The Background/ Criminal check paperwork is now in process for rest of staff.	
R247 SS=E	VII. NUTRITION AND FOOD SERVICES 7.2 Food Safety and Sanitation 7.2.b All perishable food and drink shall be labeled, dated and held at proper temperatures:	R247		

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R247	Continued From page 6 (1) At or below 40 degrees Fahrenheit. (2) At or above 140 degrees Fahrenheit when served or heated prior to service. This REQUIREMENT is not met as evidenced by: Based on record review and staff interview, the facility failed to ensure that refrigeration/freezer temperature logs are maintained to identify that all perishable food and drink is held at the proper temperature. Findings include: Per tour at approximately 9:30 AM in the presence of the owner, both freezers in the basement and one refrigerator in kitchen have no evidence that temperature logs are maintained. Confirmation was made by both owners that temperature logs are not completed for any of the refrigeration in the home.	R247	Thermometers for Freezers and Refridgerators have been procured. Daily temperature records/readings are being kept	
R267 SS=E	IX. PHYSICAL PLANT 9.1 Environment 9.1.b All homes shall comply with all current applicable state and local rules, regulations, codes and ordinances. Where there is a difference between codes, the code with the higher standard shall apply. This REQUIREMENT is not met as evidenced by: Based on observation, record review and confirmed by the home's owners the facility failed to have the two (2) boilers inspected by a licensed inspector, as indicated by the Vermont Fire and Building Safety Code 2012 (Section	R267	There are only 3 boiler inspectors for the state. Lake Talbot from Factory Mutual Insurance Co. N. Troy, Vt. will call after Thanksgiving for an appointment.	

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R267	Continued From page 7 6-Boiler and pressure Vessel Inspection) within the two (2) year required timeframe. The findings include the following: Per facility tour at approximately 9:20 AM, in the presence of one of the two the owners, confirmation is made that there are two (2) furnaces as follows: 1. Propane Furnace located in the cellar below the newer building (entrance from the bulkhead outdoors), identifies an inspection date of 3/24/08. 2. Oil Furnace in the basement, located below the original home (entrance from inside the home), identifies and inspection expiration dated of 2/24/14. Confirmation is made at approximately 1 PM by the owner that the furnaces have not been inspected and h/she was unaware of the need to contact the inspector for the review.	R267		
R302 SS=E	IX. PHYSICAL PLANT 9.11 Disaster and Emergency Preparedness 9.11.c Each home shall have in effect, and available to staff and residents, written copies of a plan for the protection of all persons in the event of fire and for the evacuation of the building when necessary. All staff shall be instructed periodically and kept informed of their duties under the plan. Fire drills shall be conducted on at least a quarterly basis and shall rotate times of day among morning, afternoon, evening, and night. The date and time of each drill and the names of participating staff members shall be documented.	R302		

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R302	Continued From page 8	R302		

This REQUIREMENT is not met as evidenced by:
Based on record review and confirmed by the owner, the facility failed to conduct fire drills quarterly rotating times of day among morning, afternoon, evening and night times. The findings include the following:

Fire Drills are documented as conducted in 2015 as follows:
4/21/16 at 10:55 AM
2/25/16 at 3:35 PM
2/20/15 the alarm was inspected and was triggered to alarm, but drill was not conducted
5/13/15 at 2:30 PM
2/17/15 at 11 AM
2/10/15 at 3:15 PM
9/15/14 at 11 AM

Confirmed at 9:46 AM by one of two owners, that the fire drills have not been conducted as required. The owner confirmed that s/he will not do a drill during the night and wake residents up and acknowledges that she is not good with paper work.

Fire Drills will be done quarterly during the 4 times of days prescribed.
First Fire Drill was on 11-23-16 at 1:28pm.
All residents were evacuated in 2min.

Answers to the Four Elements of Inspection Report

--What actions Windover House will take to correct the deficiencies?

--What measures will be put into place/systemic changes to ensure the deficiencies will not recur?

--How will the corrective actions be monitored?

--Dates that the corrective actions will be completed?

1. Reassessments on Residents #2 and #3 were completed on 10-31-16 and 11-2-16. The nurse will check each resident's chart at the beginning of each month for possible needed reassessments.

2. The Plan of Care has been updated on all of the residents. These Plans of Care will be updated every 1-2 months and PRN should a problem arise (like a fall).

3. Resident #3 developed a vaginal odor with no discharge. She went to a gynecological doctor on 11-10-16. The pessary was removed, and she was placed on Flagyl for 7 days. The vaginal odor is gone. Her Plan of Care reflects what symptoms the staff are to look for in this patient (for any possible prolapse).

4. Monthly and PRN weights/vital signs are done by staff. The nurse will make sure that the weights and vital signs are recorded as the end of a month nears.

5. Education for Staff—PEAK Education Tests are now obtained each month by the RN from Gifford Medical Center. Each staff member is responsible for completing the PEAK Tests. Records/folders are kept on each staff member. The RN education records for 2016 are in the Windover House folder. The nurse is not able to be responsible for all of the staff education as he/she is only at Windover House for 2-3 hours/week. The nurse can do some on the spot teaching as a topic arises during the care of the residents. Medication teaching for the owner, Joyce Jacobs, is done as the medications are changed/stopped/added/or dosage changes are ordered by the providers on individual residents. Joyce knows that she can call the RN for any guidance.

6. The Background/Criminal Checks have been completed on the staff as of 12-2-16. A letter was sent to Windover House from Gifford Medical Center indicating the Background/Criminal Checks status of the nurse on 11-17-16. These checks will be done every 2 years (per Gifford Medical Center policy) on the staff and the nurse. The company—Compucount—completes the criminal/background checks on the staff every 2 years.

7. Thermometers have been obtained and hung in the refrigerators and freezers. Daily temperature readings are recorded. The temperatures are taken and recorded at varying times of the day/evening. If a temperature discrepancy/malfunction is noted, immediate repairs will be done.

8. The Boiler Inspection will be completed by 12-31-16. These inspections will be done every 2 years.

9. A schedule of quarterly fire drills has been prepared. The times of the fire drills will vary from days/nights—days--(7:00 AM-12:00PM); afternoon—(12:00 PM-5:00 PM); evenings—(5:00 PM-11:00 PM); and nights--(12:00 AM-7:00 AM). The first fire drill was held on 11-23-16 at 1:30 PM.

All of the residents evacuated the building in 2 minutes. A notebook of the fire drills is kept in the Windover House office and updated as the fire drills are completed.

10. Resident #1—The resident who needed a higher level of care was admitted to Gifford Medical Center on 11-16-16 for 6 days for increasing weakness/failure to thrive/not eating or drinking food/fluids. She was permanently placed in a nursing home on 11-22-16.

Joyce W. Jacobs 12-14-16

Catherine H. Clark, R.N.
Windover House